Cabinet for Health and Family Services
Office of Health Policy
Data Advisory Subcommittee
Thursday, August 3, 2006
1:30 PM – 4:00 PM
Salato Wildlife Center

Agenda

1. Call to Order
   - Charlie Kendell, CHFS Department for Public Health

2. Welcome and Introductions

3. Approval of Minutes (May 4, 2006 meeting) [1]

4. Presentations: KIPRC and Kentucky Hospital Discharge Data
   * Current and Future Projects [2]
     - Mike Singleton, KIPRC
   * Linking Datasets to Characterize Occupational Falls [3]
     - Dr. Terry Bunn, KIPRC

5. New Business
   a. Discharge data submission via the 837 format [4, 5, 6]
      - Paige Franklin, KHA

6. Old Business
   a. Transparency update
      - Chris Corbin and Mark Fazey, CHFS Office of Health Policy
   b. Release of public use data to KY academia update [7]
      - Mark Fazey, CHFS Office of Health Policy

7. Committee Housekeeping
   a. Future Meeting Dates/Times/Location
      - Thursday Nov. 2, 1:30 PM – 4:00 PM, Salato Wildlife Center

8. Comments from the general public

9. Adjournment

HEALTH DATA ADVISORY SUBCOMMITTEE
May 4, 2006
1:30 p.m.

MEMBERS PRESENT:

James Berton King's Daughters Medical Center	Ron Crouch University of Louisville Data Center	Paige Franklin. Kentucky Hospital Association
Wayne Higgins, Ph.D. Western Kentucky University	Carol Ireson UK Center for Health Services Management and Research	John Lewis, M.D. Health Care Excel
Tim Marcum Baptist Hospital East	George Robertson Department for Public Health	Paul Sinkhorn Jewish Hospital
Ben Yandell Norton Healthcare		

MEMBERS ABSENT:

Larry Bone Four Rivers Health Care Purchasing Alliance	Sherill Cronin, Ph.D. Bellarmine University	Joyce Jennings Division of Women's Physical and Mental Health
Louis Kurtz KY Dept for Mental Health and Mental Retardation	Joyce Robl Kentucky Birth Surveillance Registry	

STAFF: Cabinet for Health and Family Services, Office of Health Policy

Chris Corbin	Mark Fazey	Sheena Lewis
Tricia Okeson	Jodie Weber	Carlos Domingo
Beth Sanderson		

GUESTS: Chandra Venettozzi, Department for Employee Insurance, Personnel Cabinet
Troy Shrout, Department of Insurance
Darlene Marshall, Department for Employee Insurance, Personnel Cabinet
Marie Alagia Cull, Cull, Hayden, and Vance, PSC.

CALL TO ORDER

Tricia Okeson called the meeting to order at the Salato Wildlife Center.

WELCOME AND INTRODUCTIONS

Tricia welcomed the committee and guests.

APPROVAL OF MINUTES

Minutes from the February 2, 2006 meeting were approved as presented.

PRESENTATION

Web-based Elective Surgery Reports (CHFS Transparency – Phase 1) Mark Fazey presented sample reports he had created using elective surgery data taken from the UB92 hospital data. Data for the most often performed procedures from July 2004 through June 2005 was used for the reports. Medians and percentiles were utilized. The information was extracted then imported into a spreadsheet. Basic explanatory notes are included in the spreadsheet. The use of notes is anticipated for the website.

Dr. John Lewis asked about the definition of the "charge" being used in the reports. Mark stated that the numbers are actual bill charges taken from UB92. This does not reflect the actual payment amount.

Mark solicited suggestions regarding whether a summary for 20 cases or less should be included or if they should be left out entirely. Ben Yandell suggested summarizing those cases in order not to lose the numbers.

Ben also suggested presenting data using each severity level and not including data for "all" severity levels.

This analysis mirrors KHA's data except OHP are using elective procedures, rather than DRGs. RDRG severity levels are the same as those used by the Kentucky Hospital Association.

There was some discussion on whether charge data was the appropriate information to release. Mark presented a way to estimate the costs which is also problematic. The consensus of the committee was that while releasing charge data has its problems, it is more important to release some data. Ultimately, the group recommended not including data related to the cost/charge ratio that is included in CompData.

Tim Marcum suggested hospitals be able to include self-pay and charity policies on OHP Transparency website.

Phase One of the website will include static tables making information available in a timely manner. OHP will collaborate with KHA in order to compliment each other.

Dr. Lewis suggested age-adjusting the data as well.

Paul Sinkhorn asked if hospitals would be able to review data before it goes live. Chris stated that per legislation, they will have 30 days to review data.

NEW BUSINESS

Chris Corbin gave an update on 2006 legislation. There were three bills significant to transparency introduced in the 2006 session. Transparency was brought to the forefront during this legislative session. Senator Tom Burch is a strong supporter. HB622 and HB445 both contained similar language on transparency. Neither bill passed independently but the language was included in HB380, the budget bill, which has passed. The bill provides a structure for using quality indicators and specific sections were included in the meeting packets. Trish stated that additional sections of HB 380 regarding data collection would be sent to members. Chris encouraged members to read HB 380.

The American Hospital Association is also working on requirements for states to work with insurers to provide information to consumers.

OLD BUSINESS

The Secretary's Data Committee on Transparency met on March 28, 2006. The meeting was very productive and there was good dialogue. The next Committee meeting will be held in September. A website prototype will be made available prior to the meeting. OHP have been working with internal sources to make this happen.

Copies of the data use agreement, along with changes suggested by Carol Ireson and Wayne Higgins were distributed prior to the meeting.

The committee discussed a mechanism to release UB-92 data to the Schools and Colleges of Public Health in the state. Tim Marcum asked if there would be a charge for the dataset. Mark answered that there is currently no charge if the data is released to an academic institution. Dr. Lewis mentioned difficulty in controlling the flow of data. Carol Ireson

stated that this issue is covered by bullet #2 and #3 of the data agreement. It was suggested to include the second section of the H-CUP Data Use agreement regarding HIPAA. Carol Ireson also suggested that if a student is requesting the dataset, approval should be received from a faculty member.

KHA will release data on Quality Indicators for review within the next two weeks. Paige Clements is checking on the status of the ER pilot study and how the data can be accessed.

COMMITTEE HOUSEKEEPING

Meeting dates, time, and location for the remainder of 2006 were approved as follows: Thursday, August 3, and Thursday, November 2, 1:30-4:00 PM, Salato Wildlife Center, Frankfort, KY

COMMENTS FROM THE GENERAL PUBLIC

Trish stated that the Healthy Kentuckians 2010 Mid-Decade Review is now available and can be accessed through the Public Health website at http://chfs.ky.gov/dph/hk2010MidDecade.htm

ADJOURNMENT

The meeting was adjourned at 3:08 p.m.

Kentucky's Hospital Discharge Database

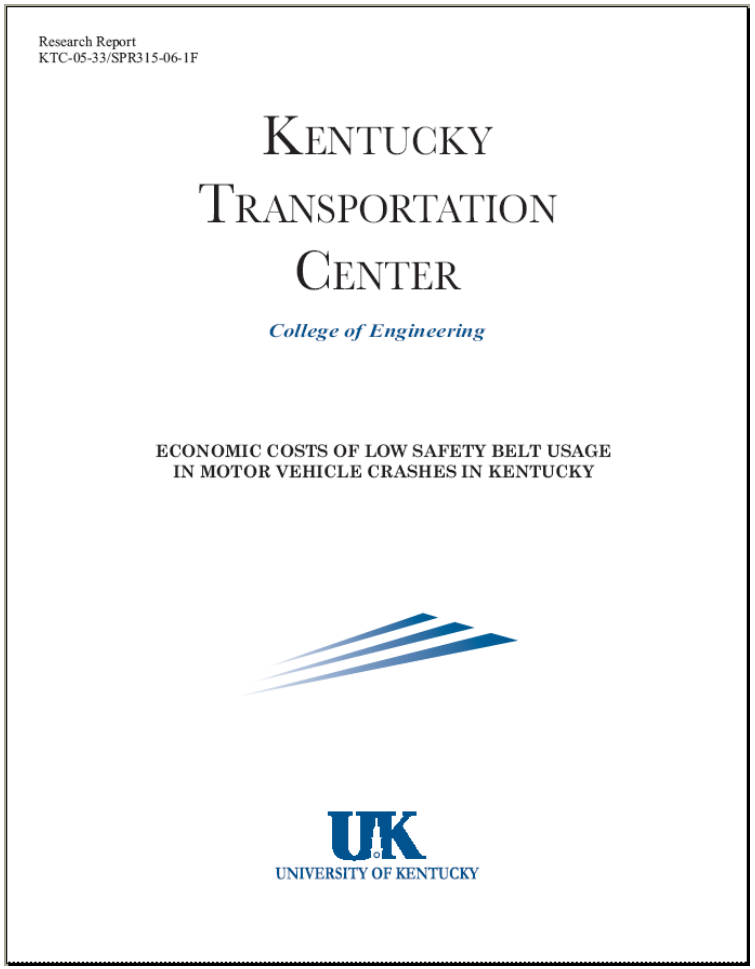
Recent Applications in Injury Prevention and Control

Michael Singleton, Lei Yu, Jenny Qin

Kentucky Injury Prevention and Research Center

August 3, 2006

Highway safety



- 2006 General Assembly: Primary safety belt enforcement bill
- Our charge: Estimate potential long-term, direct medical cost savings to Medicaid
- Methods based on Chaudhary/Preusser
- Extrapolated from known discharges, plus findings from other research studies
- $31 million in direct Medicaid savings from 2006 to 2015
- Copies available for download at http://highwaysafety.ky.gov/trafficrecords/other/economic_low_usage.pdf

State plan for injury prevention and control

- Five-year grant from CDC
- Strengthen infrastructure of state injury prevention programs
- Create injury planning group
- 26 members
- Develop and implement a statewide, integrated strategic plan to reduce the injury burden in Kentucky

State plan for injury prevention and control

Focus areas and workgroups:

- Unintentional injuries
- Violence (a.k.a. intentional injuries)
- Occupational injuries
- Cross-cutting factors
- Long-term consequences of injuries

What are the major injury/violence issues?

Leading mechanisms of injury-related discharges of Kentucky residents from licensed, acute-care hospitals in Kentucky by age group (2000-2004)

	Age group											
Rank	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total
1	Falls	Falls	Falls	MVTC	MVTC	MVTC	Falls	Falls	Falls	Falls	Falls	Falls
	113	340	877	4,546	3,087	3,008	2,959	3,603	5,922	11,528	9,690	39,388
2	Maltreatment	Poisoning	MVTC	Poisoning	Poisoning	Poisoning	MVTC	MVTC	MVTC	MVTC	MVTC	MVTC
	87	208	857	1,893	2,087	2,285	2,326	1,528	1,128	957	282	17,962
3	MVTC	MVTC	Other Trans[1]	Falls	Falls	Falls	Poisoning	Poisoning	Poisoning	Poisoning	Not Spec	Poisoning
	42	201	501	866	1,317	2,173	1,309	398	347	308	132	8,363
4	Fire/Burn	Fire/Burn	Other Pedal Cyc	Other Trans[1]	Poisoning	Poisoning	Poisoning	Poisoning	Overexertion	Not Spec	Poisoning	Poisoning
	39	182	277	783	651	773	644	380	135	201	121	4,055
5	Suffocation	Natural/Envir	Struck	Poisoning	Other Trans[1]	Other Trans[1]	Other Trans[1]	Other Trans[1]	Other Trans[1]	Overexertion	Overexertion	Other Trans[1]
	20	94	235	520	558	554	455	254	132	136	68	3,394
6	Poisoning	Struck	Poisoning	Poisoning	Poisoning	Poisoning	Poisoning	Struck	Natural/Envir	Other Spec	Struck	Struck
	19	58	206	404	437	512	341	173	125	115	63	2,055
7	Not Spec	Other Spec	Natural/Envir	Struck	Struck	Struck	Struck	Natural/Envir	Poisoning	Struck	Other Spec	Poisoning
	18	51	148	350	309	355	271	149	122	114	54	2,007
8	Other Spec	Other Trans	Fire/Burn	Struck	Struck	Struck	Natural/Envir	Poisoning	Struck	Natural/Envir	Natural/Envir	Fire/Burn
	14	41	133	261	257	316	256	141	118	98	52	1,635
9	Not Spec	Cut/Pierce	Other Spec	Firearm	Fire/Burn	Fire/Burn	Fire/Burn	Machinery	Fire/Burn	Other Trans[1]	Other Trans[1]	Natural/Envir
	12	31	112	210	223	287	232	137	116	85	30	1,539
10	Struck	Drowning	Poisoning	Fire/Burn	Other Spec	Natural/Envir	Machinery	Fire/Burn	Not Spec	Fire/Burn	Fire/Burn	Other Spec
	11	28	84	186	205	265	180	136	114	74	27	1,342

Remark: 1. Other transportation includes ATV, other offroad vehicles, animals being ridden and more.

Legend:

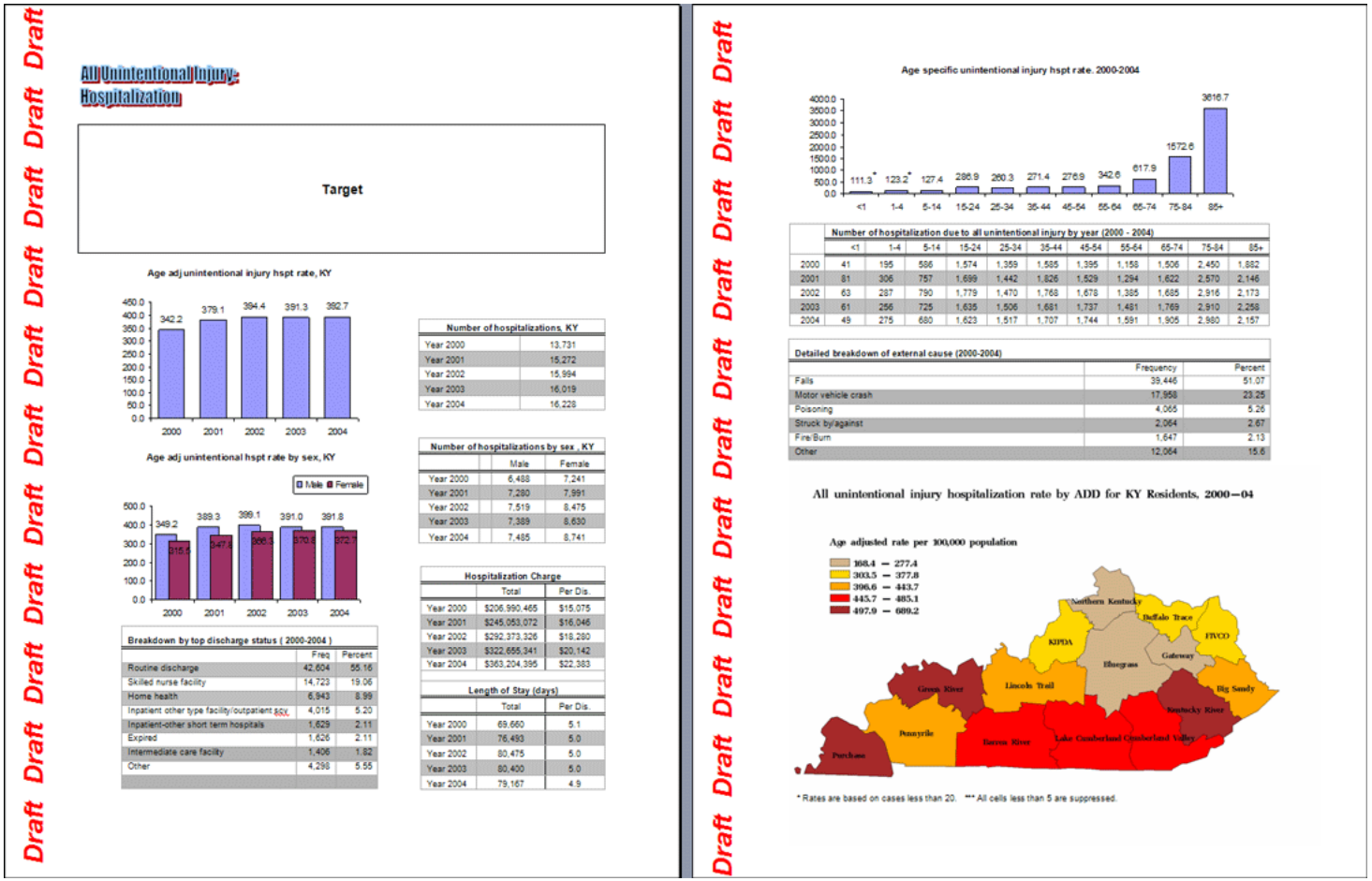
Uninterntional

Assault

Undetermined

Self inflict

Who is affected by specific causes?



All Unintentional Injury: Hospitalization

Target

Age adj unintentional injury hspt rate, KY

Number of hospitalizations, KY	
Year 2000	13,731
Year 2001	15,272
Year 2002	15,994
Year 2003	16,019
Year 2004	16,228

Age adj unintentional hspt rate by sex, KY

Number of hospitalizations by sex , KY	Male	Female
Year 2000	6,488	7,241
Year 2001	7,280	7,991
Year 2002	7,519	8,475
Year 2003	7,389	8,630
Year 2004	7,485	8,741

Breakdown by top discharge status (2000-2004)	Freq	Percent
Routine discharge	42,604	55.16
Skilled nurse facility	14,723	19.06
Home health	6,943	8.99
Inpatient other type facility/outpatient &EV	4,015	5.20
Inpatient-other short term hospitals	1,629	2.11
Expired	1,626	2.11
Intermediate care facility	1,406	1.82
Other	4,298	5.55

Hospitalization Charge	Total	Per Dis.
Year 2000	$206,990,465	$15,075
Year 2001	$245,053,072	$16,046
Year 2002	$292,373,326	$18,280
Year 2003	$322,655,341	$20,142
Year 2004	$363,204,395	$22,383

Length of Stay (days)	Total	Per Dis.
Year 2000	69,660	5.1
Year 2001	76,493	5.0
Year 2002	80,475	5.0
Year 2003	80,400	5.0
Year 2004	79,167	4.9

Age specific unintentional injury hspt rate, 2000-2004

Number of hospitalization due to all unintentional injury by year (2000 - 2004)	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
2000	41	195	586	1,574	1,359	1,585	1,395	1,158	1,506	2,450	1,882
2001	81	306	757	1,699	1,442	1,826	1,529	1,294	1,622	2,570	2,146
2002	63	287	790	1,779	1,470	1,768	1,678	1,385	1,685	2,916	2,173
2003	61	256	725	1,635	1,506	1,681	1,737	1,481	1,769	2,910	2,258
2004	49	275	680	1,623	1,517	1,707	1,744	1,591	1,905	2,980	2,157

Detailed breakdown of external cause (2000-2004)	Frequency	Percent
Falls	39,446	51.07
Motor vehicle crash	17,958	23.25
Poisoning	4,065	5.26
Struck by/against	2,064	2.67
Fire/Burn	1,647	2.13
Other	12,064	15.6

All unintentional injury hospitalization rate by ADD for KY Residents, 2000–04

* Rates are based on cases less than 20. ** All cells less than 5 are suppressed.

State plan for injury prevention and control

Assessment of death certificate and hospital discharge data systems for injuries

- Document system operation
- Quality control/assurance
- Data accuracy
- Data completeness
- Recommendations
- Planning group web page: http://michaelandjello.net/injury-plan.htm

Linking Datasets to Characterize Occupational Falls

Terry Bunn, Svetla Slavova, Arne Bathke

Occupational Falls

- 815 fatal occupational falls in 2004, ↑ 17% from 2003
- 4400 Kentucky nonfatal worker falls involving days away from work; 10 fatal
- 3,631 work-related hospitalizations in 2004 in Kentucky (↓ from 3858 in 2002 with an annual crude rate of 208/100,000 FTE)
- Primary external cause of injury was due to falls (n=289)

Workers' Claims Data

- 36,986 first reports of injury in 2004 (35,016 in 2002)
- Annual crude injury rate of 1887/100,000 FTE
- 6,008 first reports of injury were due to falls in 2004

Data Linkage

- Years 2000-2004 hospitalization UB-92 and Workers' Claims data sets linked
- Probabilistic data linkage- LinkSolv software (Strategic Matching Inc.) in Access format
- Common data variables matched: date of birth, gender, date of injury, date of hospital admission, cause of injury (falls)

Selection Criteria

- Hospitalization Cases
  - ICD-9-CM e-codes (E880-E886.9, E888 E957.0-.9, E968.1, E987.0-.9) for falls
  - Payer code of Workers' Compensation
- International Association of Industrial Accident Boards and Commissions Electronic Data Interchange Nature (IAIABCEDIN) injury codes of falls and slips

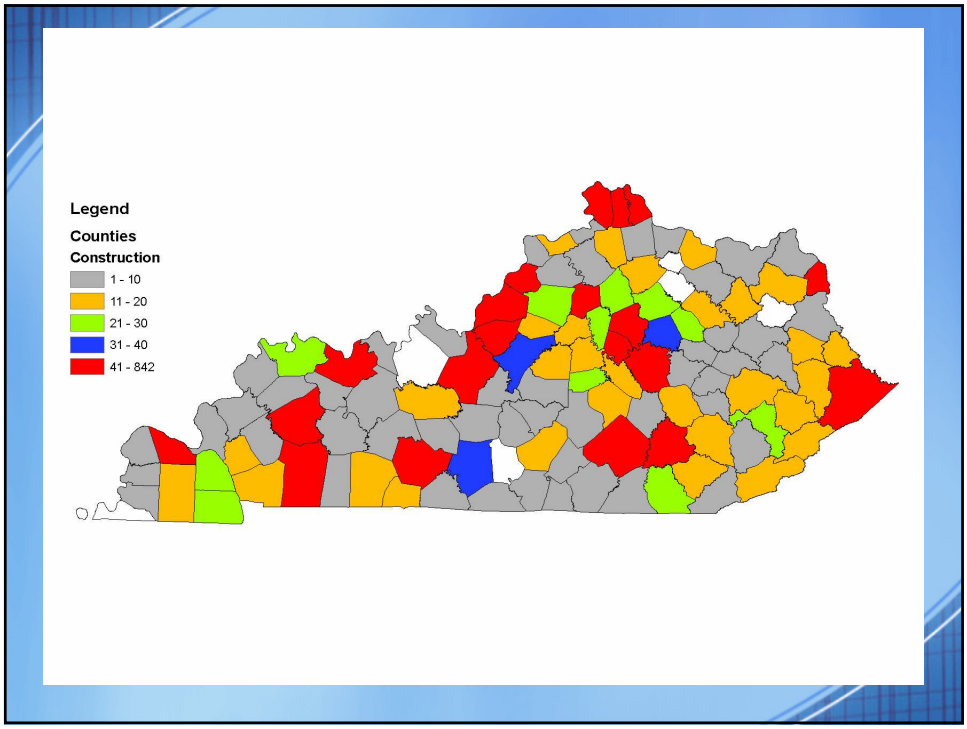
	Workers' Claims Cases	Hospitalization Cases	
Year		**Falls**	**Total**
2004	6,008	321 (16%)	2056
2003	6,056	309 (17%)	1779
2002	6,510	322 (16%)	2020
2001	6,503	348 (17%)	1989
2000	6,587	281 (16%)	1758
Total	31,664	1,581	9602

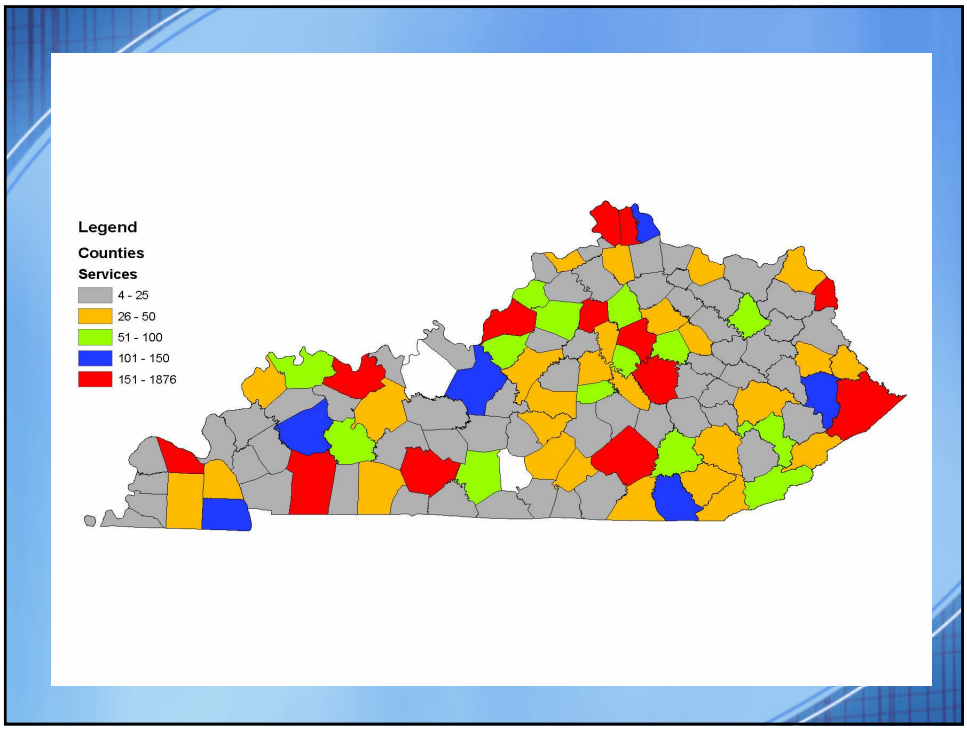
Linked Cases

Year	Number	Percentage Linked
2004	168	52%
2003	137	45%
2002	172	53%
2001	189	54%
2000	156	55%
Total	822	52%

Industries Where Falls Occurred

Males	Construction (n=254) (43%)	Manufacturing (n=79) (13%)	Services (n=68) (12%)
Females	Services (n=107) (46%)	Retail Trade (n=61) (26%)	Manufacturing (n=31) (13%)


Legend
Counties
Construction
1 - 10
11 - 20
21 - 30
31 - 40
41 - 842


Legend
Counties
Services
4 - 25
26 - 50
51 - 100
101 - 150
151 - 1876

Primary Diagnosis

Males	Lower leg & ankle injuries (n=99)	Forearm/elbow injuries (n=72)	Hip injuries (n=62)
Females	Lower leg & ankle injuries (n=63)	Hip injuries (n=49)	Forearm/elbow injuries (n=21)

External Cause of Injury

Males	Fall or Slip from different level (n=265) (44%)	Fall or slip from ladder or scaffold (n=199) (33%)	Fall, Slip, Trip NOC (n=59) (10%)
Females	Fall or slip on same level (n=86) (36%)	Fall, Slip, Trip, NOC (n=83) (34%)	Fall or slip from liquid or grease (n=40) (17%)

Workers' Claims Awards

- 332 Awards out of 822 cases to date
- 44 Pending awards
- 5 Judgments appealed
- 7 cases were dismissed or closed
- 281 Permanent partial disability awards
- 19 Permanent total disability awards
- 20 Medical waivers
- Median workers' claims award- $21,000: male workers, $9236: female workers
- Median hospital charges- $11,760

Statistical analysis

- Non-parametric analysis of factorial data
- Dependent variables- Total claim amount, total hospitalization charges, hospitalization length of stay
- Independent variable- industry
- Age and gender controlled

- Hospitalization and workers' claims costs are significantly higher in construction and mining than in the other industries

Statistical Analysis of Male Construction Worker Falls

- 244 linked cases
- 56% due to fall or slip from different level

Hospitalization Variables	Fall- diff level (n=136)	Fall- ladder/ scaffold (n=108)	Significance[a]
Length of stay	Median= 4 days Mean= 6.6±6.4	Median= 3.8 days Mean= 3±4.1	**p<0.05**
Long Stays (≥ 7 days)	31%	8%	**p<0.05**
Total Charges (p<0.05)	Median= $17,900 Mean= $34,200±$45,100	Median= $13,100 Mean= $19,500±$24,800	**p<0.05**

[a] Wilcoxon Mann Whitney two sample test, two-sided

Workers' Claims Variables	Fall- diff level (n=64)	Fall- ladder/ Scaffold (n=45)	Significance[a]
Disability	Median= 8.5% Mean= 18.8%	Median= 6% Mean= 13.1%	p=0.32
Impairment	Median= 0% Mean= 10.3%	Median= 0% Mean=3.6%	p=0.25
Award Amount	Median= $27,316 Mean= $106,820	Median= $24,000 Mean= $52,493	p=0.51

[a] Wilcoxon Mann Whitney two sample test, two-sided

Hospitalization Variables	Carpenters & Apprentices (n=53)	Laborers & Helpers (n=63)	Roofers (n=29)	Other Construction Workers (n=98)	P-value[a]
Length of stay	Median= 4 Mean= 6.7	Median= 4 Mean= 5.3	Median= 3 Mean= 6.1	Median= 3 Mean= 4.4	p=0.24
Total Charges (p<0.05)	Median= $19,104 Mean=$34,670	Median= $17,068 Mean=$28,887	Median= $15,591 Mean= $31,527	Median= $13,039 Mean= $21,896	p= 0.15
Cause of injury	Diff level-58%	Diff level-56%	Diff level-83%	Diff level-47%	**p<0.05**

[a] Kruskal Wallis test

Workers' Claims Variables	Carpenters & Apprentices (n=28)	Laborers & Helpers (n=25)	Roofers (n=16)	Other Construction Workers (n=40)	P-value[a]
Disability	Median= 5.9% Mean= 14.4%	Median= 7% Median= 17.1%	Median= 6.5% Mean= 16.5%	Median= 8.3% Mean= 17.4%	p=0.91
Impairment	Median= 0.3% Mean= 5.7%	Median= 0% Mean=8.4%	Median= 0% Mean= 6.9%	Median= 0% Mean=8.5%	p=0.76
Award Amount	Median= $22,933 Mean= $74,748	Median= $32,000 Mean= $75,970	Median= $14,000 Mean= $111,769	Median= $38,717 Mean= $85,466	p=0.42

[a] Kruskal Wallis test

Hospitalization Variables	Carpenters & apprentices (n=53)			Laborers, Helpers (n=63)		
	Fall- diff level (n=31)	Fall- ladder/ scaffold (n=22)	P-value	Fall- diff level (n=35)	Fall- ladder/ scaffold (n=28)	P-value
Length of stay	Median= 6 days Mean= 8 days	Median= 2.5 days Mean= 4.7 days	**p<0.05**	Median= 5 days Mean= 6.7 days	Median= 3 days Mean= 3.5 days	**p<0.05**
Total Charges	Median= $24,400 Mean= $39,800	Median= $13,200 Mean= $27,400	p=0.10	Median= $28,700 Mean= $38,400	Median= $14,000 Mean= $17,100	**p<0.05**

Hospitalization Variables	Roofers (n=29)			Other construction workers (n=98)		
	Fall- diff level (n=24)	Fall- ladder/ scaffold (n=5)	P-value	Fall- diff level (n=46)	Fall- ladder/ scaffold (n=52)	P-value
Length of stay	Median= 3.5 Mean= 6.8	Median= 3 Mean= 3	p=0.30	Median= 3 Mean= 5.4	Median= 3 days Mean= 3.6 days	**p<0.05**
Total Charges	Median= $17,900 Mean= $35,800	Median= $9,200 Mean= $13,000	p=0.28	Median= $13,400 Mean= $26,500	Median= $12,400 Mean= $17,800	p= 0.45

Summary

- Construction work is associated with the highest hospitalization and workers' claims costs in males who fall, whereas most female worker falls occurred in the services industry.
- The largest percentage of male worker falls was from one level to another, while the largest percentage of females experienced a fall, slip, or trip.

- Male construction laborers & helpers had longer hospital stays as well as higher total costs when the worker fell from one level to another.

Conclusions

- Data linkage of hospitalization and workers claims falls data provides additional information on industry and occupation, and costs that are not available when examining either data set alone.
- This data linkage identified male construction workers as the worker population most at risk for an occupational fall.

Conclusions (cont'd)

- A combination of interventions, safety training, and occupational safety and health enforcement targeting construction workers is warranted to reduce the burden of occupational falls in Kentucky.

The evolution of the ANSI ASC X12N 837 Format from the UB-92 Flat file format (http://phdatastandards.info/knowresources/papers/evol_ANSI.htm)

Bob Davis ***(January 13, 2004)***

Introduction

The purpose of this document is to provide background information on the ANSI ASC X12N 837 standard format(1) and to describe similarities and differences between this standard and the UB-92 format.

The goals for this document are:

1. to provide the user with a structural overview of the UB-92 flat file format;
2. to provide the user with a structural overview of the ANSI ASC X12 837 standard; and
3. to discuss the differences (gaps) and congruencies between the two formats.

The document attempts to accomplish these goals using clear and logical language, without excessive technical jargon.

Overall, the ANSI ASC X12 837 format and the UB-92 flat file format are more similar than they are different. Both formats are designed to support data content detailed in the institutional UB-92 Data Specifications document maintained by the National Uniform Billing Committee (NUBC).(2)

Background

The ANSI ASC X12 837 standard provides the following text describing the purpose of this transaction set.

"This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment.

For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment."(3)

The Health Care Service Data Reporting Guide (HCSDRG) derives its name from the language above that permits use of the 837 standard for use in reporting health care services. This is the same standard that is used to report institutional claim adjudication information for payment to private and public payers. Separate 837 implementation guides have been developed by the ANSI ASC X12N Task Group 2 Work Group 2 for payment of institutional, professional, and dental health care claims. A fourth implementation guide has been written for the reporting of health care services. It has been given the following name by the ANSI ASC X12N organization: 004050X156.(4)

The existing de facto standard for reporting health services performed in an institutional setting to public and

private entities on a mandated and voluntary basis is the UB-92 flat file format.(5) Though this format has been widely used for this reporting purpose across the country by state and private entities, this standard is a proprietary format maintained by Medicare. Since different states have different reporting requirements, the UB-92 flat file format reserves data elements and record types for individual state assignment. The HIPAA legislation will make the current UB-92 flat file formats maintained by Centers for Medicare and Medicaid Services obsolete once HIPAA transactions and codes are fully implemented. For advocates of standards, the UB-92 flat file format has 3 inherent problems:

1. Changes in the data elements and record types shared with Medicare are subject to the proprietary needs of the Medicare program.
2. Individually defined state data elements and record types promotes a non-standard solution for state data collection systems.
3. After the HIPAA transactions and codes law is implemented, this format will no longer be maintained even for the proprietary Medicare uses.(6)

Format Overview

Both the 837 and the UB-92 formats support the reporting of information referred to here as "what is wrong with the patient, what services did the patient receive, how much does it cost" information. Information in the "what is wrong with the patient" category includes diagnoses and disposition of the patient related to an episode of care. Information in the "what services did the patient receive" category includes procedures, while information in the "how much does it cost" category includes the charge information related to that same episode of care. Both formats also support the reporting of patient demographics for identifying and statistical purposes. The structure of how each format accomplishes the reporting of this information is different and will be the main topic of discussion for the remaining sections of this paper.

UB-92 Flat File Format Basics

The data content in the UB-92 flat file format is predominately the data defined by the National Uniform Billing Committee in the UB-92 Specifications Document, which is available on the NUBC web site (www.nubc.org). UB-92 flat file is organized by Record Types and data elements within those record types. Each of the record types is a fixed record length of 192 characters of information that is logically arranged by categories of information. It takes several record types to completely report a single episode of care. The record types for a single episode of care are linked together by a patient control number, which is typically the billing number. If the fixed 192 characters of information is not enough to completely report a category of information, the format allows, when appropriate, multiple sequences of those record types for that episode of care. Listed in Exhibit 1 are high level categories included in the UB-92 flat file format. The format rules for a UB-92 formatted submission allow multiple patients to be reported for each provider and it also allows for multiple providers to be reported in the same submission. The indentations are intended to help the reader organize the related record types.

Exhibit 1:
UB-92 Format Snapshot

Processor Data	--	Record Type 01		
Provider Data		--	Record Type 10	
Patient Demographics			--	Record Type 20
Patient Insurance Data			--	Record Type 30 – Sequencing Supported
Patient UB Coded Data			--	Record Type 40 & 41 – Sequencing Supported
Patient Charge Data			--	Record Type 50, 60, & 61 – Sequencing

		Supported
Patient Medical Data	--	Record Type 70 – Sequencing Supported
Patient Physician Data	--	Record Type 80 – Sequencing Supported
Patient Summary	--	Record Type 90
Provider Summary	--	Record Type 95
Process Summary	--	Record Type 99

Note: The UB-92 format reserves some record types within each category area to be used for local assignment. Listed below are those record types by category.

Patient Demographics	--	Record Type 25-29
Patient Insurance Data	--	Record Type 35-39
Patient UB Coded Data	--	Record Type 45-49
Patient Charge Data	--	Record Type 55-59 & Record Type 65-69
Patient Medical Data	--	Record Type 79
Patient Physician Data	--	Record Type 85-89

UB-92 Example

Exhibit 2 is an example of a typical UB-92 submission reporting services provided by two providers for a total of 3 patients. In this example Scott Greene and Nancy Best were discharged from Too Good Hospital and Bill Dunnet was discharged from All Right Hospital

Exhibit 2:
UB-92 Submission Sample (2 providers, 3 patients)

RT 01 containing Submission information

RT 10 containing identifying information about Too Good Hospital

RT 20 containing demographic information about Scott Greene
RT 30 containing insurance information about Scott Greene
RT 40 containing UB coded information about Scott Greene
RT 41 containing more UB coded information about Scott Greene
RT 50 containing Accommodation Charge information about Scott Greene
RT 60 containing Ancillary Charge information about Scott Greene
RT 70 containing Medical information about Scott Greene
RT 80 containing Physician information about Scott Greene
RT 90 containing Summary information about Scott Greene

RT 20 containing demographic information about Nancy Best
RT 30 containing insurance information about Nancy Best

RT 40 containing UB coded information about Nancy Best

RT 41 containing more UB coded information about Nancy Best

RT 50 containing Accommodation Charge information about Nancy Best

RT 60 containing Ancillary Charge information about Nancy Best

RT 70 containing Medical information about Nancy Best

RT 80 containing Physician information about Nancy Best

RT 90 containing Summary information about Nancy Best

RT 95 containing Summary information about Too Good Hospital

RT 10 containing identifying information about All Right Hospital

RT 20 containing demographic information about Bill Dunnet

RT 30 containing insurance information about Bill Dunnet

RT 40 containing UB coded information about Bill Dunnet

RT 41 containing more UB coded information about Bill Dunnet

RT 50 containing Accommodation Charge information about Bill Dunnet

RT 60 containing Ancillary Charge information about Bill Dunnet

RT 70 containing Medical information about Bill Dunnet

RT 80 containing Physician information about Bill Dunnet

RT 90 containing Summary information about Bill Dunnet

RT 95 containing Summary information about All Right Hospital

RT 99 containing Submission Summary information

ANSI ASC X12 837 Format Basics

The data content in the ANSI ASC X12N 837 format is predominately the data defined by the National Uniform Billing Committee in the UB-92 Specifications Document, which is available on the NUBC web site (www.nubc.org).

The ANSI ASC X12 syntax is organized by loops, segments, and data elements. Loops are made up of segments and segments are made up of data elements. Each data element is variable length with the standard minimum and maximum length. The loops are organized by categories of information. In the 837 format related categories of information are associated by their hierarchy as defined by an HL (hierarchical level) segment. Proper coding of this HL segment allows for information on multiple providers to be reported as well as information for multiple patients for each provider to be reported. The HL segment defines a parent-child relationship. One common situation for use of the HL segment is to define a provider as the parent and each reported patient as the child. This provides the function necessary for a provider to submit multiple claims in a single submission. Related data elements are organized in segments.

Listed in Exhibit 3 are high level categories included in the ANSI ASC X12N 837 format. The format rules for

a ANSI ASC X12N 837 formatted submission allow multiple patients to be reported for each provider and it also allows for multiple providers to be reported in the same submission. The indentations are intended to help the reader organize the related record types. The HL segment will show the relationship between that loop and the total submission and the repeats show where multiple reports are permissible. It should be noted that the ANSI ASC X12N 837 format is used for submitting claims to private and public payers as well as for reporting requirements. The subscriber loop (2000B) and the patient loop (2000C) both are reported for an encounter when the patient is DIFFERENT than the person providing the insurance coverage for that episode of care.

Exhibit 3:
ANSI ASC X12 Format Snapshots

Header

Submitter Loop 1000A
Receiver Loop 1000B

Provider Loop 2000A HL & Repeat >1

Subscriber Loop 2000B HL & Repeat >1
Patient Loop 2000C HL & Repeat >1
Claim Loop 2300 Repeat <100

Service Line Loop 2400 Repeat <999

Trailer

The 837 format supports two segments that can be used to support local data needs. These segments (K3 and NTE) are in the Claim Loop (2300). The narrative in the Health Care Service Data Reporting Guide places parameters on the use of these segments with the understanding that there are situations that require the flexibility to support locally defined data needs.

Exhibit 4 below is an outline representing the hierarchical structure of the X12-837 loops and segments for the ANSI ASC X12N 837 Health Care Service Reporting Guide (004050X156) implementation. The indentations in the outline are intended to represent hierarchical relationships. The numbers in parenthesis in the right hand margin represent permissible repeats of the associated loop.

Exhibit 4:
837 Loop and Segment Diagram

HEADER
ST Transaction Set Header
BHT Beginning of Hierarchical Transaction
REF Transmission Type Identification

LOOP ID 1000A SUBMITTER NAME (1)
NMI Submitter Name
REF Submitter Secondary Identification
PER Submitter EDI Contact Information

LOOP ID 1000B RECEIVER NAME (1)

NMI Receiver Name

Detail - Provider

LOOP ID 2000A SERVICE PROVIDER HIERARCHICAL LEVEL (1)

HL Service Provider Hierarchical Level

LOOP ID 2010A SERVICE PROVIDER NAME (1)

NM1 Service Provider Name

REF Service Provider Secondary Identification

Detail - Subscriber

LOOP ID 2000B SUBSCRIBER HIERARCHICAL LEVEL (>1)

HL Subscriber Hierarchical Level

SBR Subscriber Information

PAT Patient Information

LOOP ID 2010BA SUBSCRIBER NAME (1)

NM1 Subscriber Name

N3 Subscriber Address

N4 Subscriber City/State/Zip Code

DMG Subscriber Demographic Information

REF Subscriber Secondary Identification

LOOP ID 2010BC PAYER NAME (1)

NM1 Payer Name

REF Payer Secondary Identification

Detail - Subscriber

LOOP ID 2000C PATIENT HIERARCHICAL LEVEL (>1)

HL Patient Hierarchical Level

LOOP ID 2010CA PATIENT NAME (1)

NM1 Patient Name

N3 Patient Address

N4 Patient City/State/Zip Code

DMG Patient Demographic Information

REF Patient Secondary Identification

Claim

LOOP ID 2300 CLAIM INFORMATION (100)

CLM Claim Information

DTP Statement Dates

DTP Discharge Hour
DTP Admission Date / Hour
CL1 Claim Codes
PWK Claim Supplemental Information
AMT Payer Estimated Amount Due
AMT Patient Estimated Amount Due
REF Medical Record Number
REF Mother's Medical Record Number
K3 File Information
NTE Claim Note
HI Principal Dx, Admitting Dx, and E-code
HI Diagnosis Related Group (DRG) Information
HI Other Diagnosis Information
HI Principal Procedure Information
HI Other Procedure Information
HI Occurrence Span Code Information
HI Occurrence Code Information
HI Value Code Information
HI Condition Code Information
QTY Claim Quantity

LOOP ID 2310A ATTENDING PHYSICIAN NAME (1)
NM1 Attending Physician Name
REF Attending Physician Secondary Identification

LOOP ID 2310B OPERATING PHYSICIAN NAME (1)
NM1 Operating Physician Name
REF Operating Physician Secondary Identification

LOOP ID 2310C OTHER PHYSICIAN NAME (1)
NM1 Other Physician Name
REF Other Physician Secondary Identification

LOOP ID 2310D REFERRING PHYSICIAN NAME (1)
NM1 Referring Physician Name
REF Referring Physician Secondary Identification

LOOP ID 2320 OTHER SUBSCRIBER INFO (10)
SBR Other Subscriber Information
AMT Payer Prior Payment

LOOP ID 2330 OTHER SUBSCRIBER NAME (1)

	NM1 Other Subscriber Name
	REF Other Subscriber Secondary Identification
	LOOP ID 2330B OTHER PAYER NAME (1)
	NM1 Other Payer Name
	REF Other Payer Secondary Identification
	LOOP ID 2330C OTHER PAYER PATIENT INFO (1)
	NM1 Other Payer Patient Information
	REF Other Payer Patient Identification Number
	LOOP ID 2400 SERVICE LINE NUMBER (100)
	LX Service Line Number
	SV2 Institutional Service Line Information
	DTP Service Line Date
TRAILER	
SE	Transaction Set Trailer

ANSI ASC X12N 837 Example

Exhibit 5 is an example using the ANSI ASC X12 837 for reporting services provided to two providers for a total of 3 patients. In this example Scott Greene and Nancy Best were discharged from Too Good Hospital and Bill Dunnet was discharged from All Right Hospital. In the example below the patient is always the same as the person providing for insurance coverage for these episodes of care.

Exhibit 5:
ANSI ASC X12 837 Sample (2 providers, 3 patients)

Header
ST*837*987654~
BHT*0019*00*A12345*20010801*1800~
Loop 1000A – Submitter Name
NM1*41*2*TOO GOOD HOSPITAL*****46*999008888~
Loop 1000B – Receiver Name
NM1*40*2*MY STATE DATA AGENCY*****46*12000~
Loop 2000A – Service Provider Hierarchical Level for Too Good Hospital
HL*1**20*1~
Loop 2010AA – Service Provider Name for Too Good Hospital
NM1*85*2*TOO GOOD HOSPITAL*****24*999008888~
REF*1J*898989~
Loop 2000B – Subscriber (Patient) Hierarchical Level for Scott Greene
HL*2*1*22*1~
SBR*P********BL~
Loop 2010BA – Subscriber (Patient) Name for Scott Greene
NM1*IL*1*GREENE*SCOTT*A**MI*GRNESSC1234~
N3*1313 MOCKINGBIRD LANE~
N4*ANYTOWN*NY*09090~
DMG*D8*19760706*M**::RET:3::RET:2~
REF*SY*130281234~
Loop 2010BC – Payer Name
NM1*PR*2*EMPIRE BLUE CROSS*****PI*00303~

Loop 2300– Claim Information for Scott Greene
CLM*ABH123456*5015***11:A:1~
DTP*096*TM*1200~
DTP*434*RD8*20010610-20010611~
DTP*435*DT*200106100900~
CL1*2*1*01~
REF*EA*ABHMEDRECMOM~
NTE*UPI*STATE SPECIFIC REQUIREMENTS~
HI*BK:66411*BJ:66411~
HI*BF:66331:::::::Y*BF:66111:::::::N*BF:V270:::::::N~
HI*BR:7569:D8:20010610~
HI*BQ:7309:D8:20010610~
Loop 2310A – Attending Physician Name for Scott Greene
NM1*71*1*DOCTOR*JOE****XX*F88888~
REF*1G*JDUPIN~
REF*0B*JDSTAATE~
Loop 2310B – Operating Physician Name for Scott Greene
NM1*72*1*SURGEON*REALGOOD****XX*F99999~
REF*0B*RSUPIN~
REF*1G*RSSTA
Loop 2320 – Other Subscriber Information for Scott Greene
SBR*S********CI~
Loop 2330A – Other Subscriber Name for Scott Greene
NM1*IL*1*Greene*Beth*P~
Loop 2400 – Service Line Number for Scott Greene
LX*1~
SV2*001**5015-
LX*2~
SV2*122**2754*DA*2*1377~
LX*3~
SV2*258**15~
LX*4~
SV2*259**68~
LX*5~
SV2*279**59~
LX*6~
SV2*305**38~
LX*7~
SV2*309**39~
LX*8~
SV2*729**2034~
LX*9~
SV2*999**8~
Loop 2000B - Subscriber (Patient) Hierarchical Level for Nancy Best
HL*3*1*22*0~
PAT*********Y~
Loop 2010BA – Subscriber (Patient) Name for Nancy Best
NM1*QC*1*BEST*NANCY*E**MI*BESTNA9999~
N3*1313 MOCKINGBIRD LANE~
N4*ANYTOWN*NJ*0*09090~
DMG*D8*20010610*F**::RET:3::RET:2~
REF*SY*999999999~
Loop 2300– Claim Information for Nancy Best
CLM*ABH1234567*2343***11:A:1~
DTP*096*TM*1600~
DTP*434*RD8*20010610-20010611~
DTP*435*DT*200106100900~
CL1*4*1*01~
REF*EA*ABHMEDRECKID~
REF*MRN*ABHMEDRECMOM~

NTE*UPI*STATE SPECIFIC REQUIREMENTS~
HI*BK:V3000*BJ:V3000~
HI*BF:7625:::::::N*BF:V053:::::::N~
HI*BR:9604:D8:20010610~
HI*BQ:9955:D8:20010610~
HI*BE:54:::3610~
Loop 2310A – Attending Physician Name for Nancy Best
NM1*71*1*DOCTOR*JOE****XX*F88888~
REF*1G*JDUPIN~
REF*0B*JDSTAATE~
Loop 2310B – Operating Physician Name for Nancy Best
NM1*72*1*SURGEON*REALGOOD****XX*F99999~
REF*0B*RSUPIN~
REF*1G*RSSTATE~
Loop 2320 – Other Subscriber Information for Nancy Best
SBR*S********CI~
Loop 2330A – Other Subscriber Name for Nancy Best
NM1*IL*1*SAMPLE*TIMOTHY*O~
Loop 2400 – Service Line Number for Nancy Best
LX*1~
SV2*001**2343~
LX*2~
SV2*171**2232*DA*2*1116~
LX*3~
SV2*279**37~
LX*4~
SV2*309**63~
LX*5~
SV2*729**11~
Loop 2000A – Service Provider Hierarchical Level for All Right Hospital
HL*4**20*1~
Loop 2010AA – Service Provider Name for All Right Hospital
NM1*85*2*ALL RIGHT HOSPITAL*****24*999008888~
REF*1J*898989~
Loop 2000B – Subscriber (Patient) Hierarchical Level for Bill Dunnet
HL*5*4*22*1~
SBR*P********BL~
Loop 2010BA – Subscriber Name (Patient) for Bill Dunnet
NM1*IL*1*DUNNET*BILL*A**MI*DUETBI1234~
N3*1313 MOCKINGBIRD LANE~
N4*ANYTOWN*NY*09090~
DMG*D8*19760706*M**::RET:3::RET:2~
REF*SY*130281234~
Loop 2010BC – Payer Name
NM1*PR*2*EMPIRE BLUE CROSS*****PI*00303~
Loop 2300– Claim Information for Bill Dunnet
CLM*ABH123456*5015***11:A:1~
DTP*096*TM*1200~
DTP*434*RD8*20010610-20010611~
DTP*435*DT*200106100900~
CL1*2*1*01~
REF*EA*ABHMEDRECMOM~
NTE*UPI*STATE SPECIFIC REQUIREMENTS~
HI*BK:66411*BJ:66411~
HI*BF:66331:::::::Y*BF:66111:::::::N*BF:V270:::::::N~
HI*BR:7569:D8:20010610~
HI*BQ:7309:D8:20010610~
Loop 2310A – Attending Physician Name for Bill Dunnet
NM1*71*1*DOCTOR*JOE****XX*F88888~
REF*1G*JDUPIN~

REF*0B*JDSTAATE~
Loop 2310B – Operating Physician Name for Bill Dunnet
NM1*72*1*SURGEON*REALGOOD****XX*F99999~
REF*0B*RSUPIN~
REF*1G*RSSTA
Loop 2320 – Other Subscriber Information for Bill Dunnet
SBR*S********CI~
Loop 2330A – Other Subscriber Name for Bill Dunnet
NM1*IL*1*Dunnet*Sue*O~
Loop 2400 – Service Line Number for Bill Dunnet
LX*1~
SV2*001**5015-
LX*2~
SV2*122**2754*DA*2*1377~
LX*3~
SV2*258**15~
LX*4~
SV2*259**68~
LX*5~
SV2*279**59~
LX*6~
SV2*305**38~
LX*7~
SV2*309**39~
LX*8~
SV2*729**2034~
LX*9~
SV2*999**8~
TRAILER
SE*91*987654~

The table below identifies where the basic data categories are reported in the ANSI ASC X12N 837 and UB-92 formats. It should be noted that all categories are reported in both formats.

Exhibit 6:
ANSI ASC X12 837 and UB Format Category Crosswalk

Category	*ANSI ASC X12N 837*	*UB-92*
Submitter/Receiver	Header & 1000A	RT 01
Provider	2000A	RT 10
Subscriber/Insured	2000B	RT 30
Patient Demographics	2010ZBA 0r 2000C	RT 20
Patient UB Coded Data	2300	RT 40 & 41
Patient Medical	2300	RT 70
Patient Charges	2400	RT 50 & 60
Patient Physician	2310 A, B, C	RT 80

UB-92 Format and ANSI ASC X12 Similarities and Differences

There are two primary similarities between the UB-92 format and ANSI ASC X12 format: (1) both are used as transmission vehicles for the same institutional services UB data content; (2) both formats organize the data into similar categories. The syntax and organization of each of the formats is the source of most of the differences, which are summarized in exhibit 7. The ANSI ASC X12 formats, including the 837, have been named as a HIPAA standard. As a HIPAA standard, the 837 is now subject to a national consensus approval and maintenance process. The UB-92 flat file format is a proprietary format maintained by Medicare and adopted by many for reporting health encounters all over the country. Exhibit 7 below summarizes format differences.

Exhibit 7:
Format Gap Matrix

Gap Description	*ANSI ASC X12 837*	*UB-92*
Category/Organization	Logical order as defined in hierarchical loops and in data segments	Physical order as defined by record types
Category Linkage	Records linked by the HL segments and associated information about patient (note order is not significant)	Records links by repeating patient identifier in each related record type associated with patient specific information (note order is critical)
Format Organization	Loop requirements dependent on situational use	Record Types required based on strict syntax rules
Data Element Format	Variable length with minimum and maximum lengths defined along with a finite list of data types (i.e., numeric, date/time, character)	Fixed length with numeric or alpha-numeric field definitions
Format Maintenance	ANSI ASC X12N consensus process	Medical internal process
Transmission Medium	Designed as a vehicle for electronic (i.e., machine to machine without human intervention) data transmission	Designed as a vehicle for magnetic (i.e., tape, cartridge, diskette) data transmission

Summary

Discussion of the UB-92 flat file and the ANSI ASC X12N 837 is not a tale of competing formats, rather it is an evolutionary story. Neither format has ever been more than the prologue to a much more robust story. Both formats are designed as vehicles to simply transmit UB data content. Neither format is designed as an application system file structure. It is those application systems that can provide the ways and the means to use the data to improve the quality of health care, not the submission formats alone. The consensus process that is driving the development of the HIPAA final rules has provided the magnifying glass on the data and in so doing a the ANSI ASC X12N 837 format is evolving to better meet the needs of a larger cross section of our health delivery system. Data that are used widely are data that are highly valued.

Through better understanding of the transmission vehicles, we hope to promote greater standardization in our core health delivery systems. Through greater understanding we hope to de-mystify some of the technical wrappings of these core data. Through our technology and a growing realization about the necessity of collaboration, the goal of improved data quality needed to make the important health treatment and policy decisions in our complex modern world is more achievable today than ever before.

References

(1) It is not the intent of this document to educate the user on X12-837 transactions. This document must be used in conjunction with published ANSI ASC X12 implementation guides.
(2) This document is available for a membership fee on the NUBC Web site at www.nubc.org.
(3) Scope and Purpose of Health Care Claim Transaction (837) standard.
(4) This implementation guide is a technical document that can be downloaded from the Washington Publishing Company web site: http://www.wpc-edi.com/HealthCare_40.asp.
(5) *De facto* standards are those standards that are defined for a specific purpose and then, due to their usefulness, adopted by industries for widespread use. "Tutorial Module 5: Public Health Data Standards." Web-based Resource Center. Public Health Data Standards Consortium. Available online: http://phdatastandards.info/knowresources/tutorials/module5.htm. Accessed on January 13, 2004.
(6) The Medicare version of this format can be downloaded from the following web site: http://cms.hhs.gov/providers/edi/edi3.asp.

American Hospital Association

Preparing for a Successful Transition to the UB-04

By
George Arges
Chairman of NUBC

American Hospital Association

Presentation Objectives

- Share NUBC thoughts about the UB-04 implementation issues.
- Help health care professionals understand the changes made to the UB-04 and the implications it has on their work
- Provide an overview of the rationale behind the changes

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Background

- NUBC - National Uniform Billing Committee Created in 1975
  - 1982 - NUBC Agrees on Data Set UB-82
  - 1992 - NUBC Creates successor data set UB-92
  - 1996 - HIPAA Title II Subtitle F recognizes NUBC as one of four organizations to be consulted for the establishment of standards
  - 2000 - MOU - NUBC signs along with ANSI X12 & HL7, NCPDP, ADA, & NUCC

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Factors Influencing Changes to UB Data Set

- Compliance & Accountability
- Performance Measurements
- Health Care Planning
- Accreditation

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Rationale for the UB-04

- Better alignment with the HIPAA 837 transaction standard
- Designed to accommodate the National Provider Identifiers (NPI) and legacy numbers to ease transition issues associated with the NPI.
- Anticipates the upcoming Health Plan Identifier.
- Prepares for future migration of ICD-9-CM diagnosis reporting to ICD-10-CM.

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Rationale for the UB-04 (cont'd)

- Supports reporting of other external code lists
- Provides greater flexibility and utility when the UB is used for public health reporting needs.
- Reduce the reliance on claims attachments - by improving on the number of clinical codes one can report.

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Process Toward UB-04

- Four year effort
  - Identify data gaps with HIPAA standard
  - Examined State Codes and Form Locators
- Compiled and presented findings to NUBC
- Sought input and acted on recommendations
- Final Survey on Implementation Timeframe

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Key Changes - Additions

- Accident State
- Diagnosis Indicator
- ICD – version qualifier (ICD-9/ICD-10)
- Pay-to-location
- PPS/DRG Code
- Added unique fields for National Provider ID (NPI) & National Health Plan ID
- Code-Code Field

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Key Changes - Deletions

- Covered, Non-Covered, Coinsurance, & Lifetime Reserve Days (converted to **Value Codes**)
- Patient Marital Status
- Employment Status Code
- Employer Location
- Prior Payments – Patient
- Procedure Coding Method Used
- Provider/Representative Signature

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Key Changes - Modifications

- Bill Type – expanded field size
- Condition Codes – added four new fields
- Occurrence Codes – added additional field
- HCPCS/Rates/HIPPS Rate Codes – expanded field size for additional modifiers
- Treatment Authorization Number – expanded field size
- Diagnosis Fields – added nine new fields – expanded size to 8 characters
- Procedure codes – expanded field size by one

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Basis for Moving Forward

- Shifts in the financing of health care
  - Activity based payment
    - Listing of all services provided
  - Performance based payment
    - Quality & Outcome
- Who is behind this shift?
  - Employers
  - Legislators

American Hospital Association

UB-04 Changes

- Increased emphasis on clinical codes
  - Expanded on the number of Diagnosis and procedure codes that can be reported.
  - Preparation for ICD-10-CM & ICD-10-PCS
- HIPAA Standards
  - Alignment of data elements
- Anticipation of future shifts in financing of health care services.

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Implementation Schedule

- **March 1, 2007** – Clearinghouses & Health Plans must be ready to accept UB-04
- **March 1 through May 22, 2007** - Providers can use either the UB-92 or UB-04
- **May 23, 2007** - UB-92 is no longer acceptable – only UB-04 can be used

Suggested Steps - Internal

- Understand the differences between UB-92 and the UB-04
  - http://www.nubc.org/public/whatsnew/UB-04Proofs.pdf
- Examine and catalogue areas for change to existing information systems
- Contact Vendors – ask them when they will accommodate the changes to the UB-04
- Pull together team – patient accounting, medical records, IS&T – assign tasks

Suggested Steps - External

- State Billing Committee – convene meeting
- Awareness Campaign
  - Contact major health plans
    - Ask health plans to identify date they will be ready
    - Explore with health plans – the handling of new items to the UB-04
  - Monitor Timelines

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Conclusion

- Familiarize yourself with the overall billing process
  - Understand handling of proposed changes
  - Determine where your operational risks are the greatest
  - Develop plan to implement and attack areas that pose the greatest risk
- Make sure your organization continues to monitor NUBC developments
- Work with health plans and clearinghouses within your state so they understand the implementation schedule.

National Uniform Billing Committee

UB-04
Data Specifications Manual

Beta 1

American Hospital Association

Thank you

- Links
  - www.nubc.org
  - www.aha.org

Effective Date: March 1, 2007
Meeting Date:

Form Locator 67

Data Element **Principal Diagnosis Code**

Definition: The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.)

See FL 67 Pages 2-3 for information on the Present on Admission Indicator.

For additional information, refer to the Official ICD-9-CM Guidelines for Coding and Reporting.

Reporting

Principal Diagnosis Code
- UB-04: Required.
- 004010/004010A: Required.
- 005010: Required.

Present on Admission Indicator
See FL 67 Pages 2-3 for information on usage.

Field Attributes

1 Field
1 Line
8 positions (1-7: Principal Diagnosis Code; 8 (shaded area): Present on Admission Indicator)
Alphanumeric
Left-justified

Notes

Follow the official coding guidelines for ICD reporting.

The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

The principal diagnosis code will include the use of "V" codes.

Effective Date: March 1, 2007
Meeting Date:

Form Locator 67

Data Element

Principal Diagnosis Code

Present on Admission (POA) Indicator

The eighth digit of FL 67 - Principal Diagnosis and each of the secondary diagnosis fields FL 67A-Q.

The eighth digit of FL 72 - External Cause of Injury (ECI) (3 fields on the form).

Usage

1. The POA Indicator applies to the diagnosis codes for claims involving inpatient admissions to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting.

2. The POA Indicator is based not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place.

3. Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission.

4. The POA Indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported.

5. The five reporting options for all diagnosis reporting are as follows:

Code	Definition
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
Unreported/Not Used	Exempt from POA reporting

The American Health Information Management Association, American Hospital Association, CMS and the National Center for Health Statistics (known as the "Cooperating Parties") will publish a list of ICD-9-CM codes for which the POA indicator does not apply (left blank on a paper UB; "Not Used" on an electronic claim). The indicator can be left unreported only for the codes on this list. This list will be included in the POA guidelines published in the ICD-9-CM Official Guidelines for Coding and Reporting and updated as needed.

Effective Date: March 1, 2007
Meeting Date:

Data Element **Principal Diagnosis Code**

Present on Admission (POA) Indicator (continued)

6. The POA Indicator should also be reported for all E (External Cause) codes. "E-code" categories for which the POA Indicator is not applicable would not be reported.

7. Health plans that receive POA information on the claim should not reject the claim if their claims processing systems have no use for any of the POA information.

8. Coding professionals should follow the comprehensive guidelines on POA as published in the ICD-9-CM Official Guidelines for Coding and Reporting to further assist coding professionals in accurate and consistent reporting of all POA data. These guidelines will be updated as needed to address identified coding errors or areas of confusion.

Agreement for Use of Kentucky Health Claims Data

This agreement between the Kentucky Cabinet for Health and Family Services and the individual(s) whose signature(s) appears (appear) below, applies to all health claims data collected in compliance with KRS 216.2920-216.2947, including but not limited to subsets of patient level records in full or in part , and any and all summaries or aggregations of data which may be derived from original data or any subset thereof. In addition, this agreement implements the data protections of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-91) and in accordance with HIPAA, the data provided with this agreement may only be used for research, analysis, and aggregate statistical reporting.

Personal identifiers: Patient level health claims data have been purged of name, address, social security number, and other direct personal identifiers to prevent individual patient identification. Nevertheless, the undersigned agrees that no attempt will be made to identify individual patients through any means or methods without the expressed written permission of the Kentucky Cabinet for Health and Family Services. Furthermore, the undersigned agrees that information derived or summarized from patient-level data which could result in the identification of any specific individual will not be released or made public.

Establishment identifiers: Identifiers for hospitals, clinics, physicians, and other health care providers have been included on patient level records in compliance with the aforementioned statute for the purpose of making cost, quality, and outcome comparisons among providers. Such purpose does *not* include the use of information concerning individual providers for commercial or competitive purposes involving those providers, or to determine the rights, benefits, or privileges of such providers. Providers shall not be identified directly or by inference in disseminated material. Under this agreement, users of data shall not contact providers for the purpose of verifying received data or summaries derived therefrom.

The undersigned gives the following assurances with respect to data obtained under the terms and conditions of this agreement:

- I will ensure that the data are kept in a secured environment and that only authorized users will have access to the data;

- I will not attempt to link or permit others to attempt to link the hospital stay records of persons in this data set with personally identifiable records from any other source without prior written approval from the Kentucky Cabinet for Health and Family Services;

- I will not attempt to use or permit others to use the data sets to learn the identity of any person included in any data set;

- I will not release or disclose or permit others to release or disclose any information based on these data that identifies individuals, either directly or indirectly;

- I will not release or disclose information where the number of observations (i.e. individual discharge records) in any given cell of tabulated data is less than or equal to 10;

- I will not attempt to use or permit others to use the data to learn the identity of any provider that may be represented in the data;

- I will not contact or permit others to contact providers or persons represented in the data;

- I will not use or permit others to use data concerning individual health care providers
  (1) for commercial or competitive purposes involving those providers,
  (2) to determine the rights, benefits, or privileges of individual providers, or
  (3) to report, through any medium, data that could identify individual providers, either directly or by inference;

- I will require others in the organization specified below who use the data to sign this agreement and will keep those signed agreements and make them available upon request;

- I will not release or permit organizations or individuals outside my direct control or the control of the organization specified below to release the data sets or any part of them to any person who is not a member of the organization specified below;

- I will make no statement nor permit others to make statements implying or suggesting that interpretations drawn are those of health care providers that may be identified in the data, either individually or as a group, or of the Kentucky Cabinet for Health and Family Services or any of its Offices or Departments; and

- I will acknowledge the " Kentucky Cabinet for Health and Family Services, Office of Health Policy " as the data source in any and all publications based on these data.

Violation of this agreement will result in action by the Kentucky Cabinet for Health and Family Services. Violations deemed unlawful may be referred to the Commonwealth Attorney, the police, the Federal Bureau of Investigation, or other appropriate legal authority for investigation and/or prosecution.

Note: The researcher(s) signing this data use agreement must be the person(s) to whom the data product is released. Student researchers' signatures must be accompanied by the signature of their faculty advisor or project director. A copy of Institutional Review Board approval of this project must also be included with this sheet.

Researcher

Signed: _____ Date: _____

Printed or typed name of data recipient: _____

Organization and Title: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____

Researcher

Signed: _____ Date: _____

Printed or typed name of data recipient: _____

Organization and Title: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____

Faculty Advisor/Project Director

Signed: _____ Date: _____

Printed or typed name of data recipient: _____

Organization and Title: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____